COVID-19 Serious Incident Review Sub-Committee Findings Report – Delta Variant

Version 2

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Purpose of this report

This report analyses COVID-19-related Serious Incident Reviews (SIRs) reported during a time of unprecedented demand on the NSW health system due to the Delta variant outbreak. It highlights system issues and learnings in NSW Health service provision identified through Serious Adverse Event Reviews (SAERs), Corporate Reviews and discussions held at the COVID-19 SIR Sub-Committee. The Clinical Excellence Commission (CEC) acknowledges the commitment of NSW Health staff at all levels to provide the best care possible to the people of NSW during a time of significant challenge and their efforts in simultaneously investigating incidents.

Scope

This report includes information identified in all COVID-19 SAER or Corporate Reviews that were discussed at the COVID-19 SIR Sub-Committee, and reported internally to the Clinical Risk Action Group (CRAG) during the period of July to October 2021. A total of 31 cases, including 27 clinical and four corporate cluster reviews, are included. This report provides a thematic analysis of the these cases that were discussed at three meetings (10 and 24 November and 8 December, 2021) and provides a snapshot of COVID-19 serious incidents data during the Delta variant outbreak.

Introduction to COVID-19 Serious Incident Reviews

Background

The COVID-19 pandemic was declared on 22 March 2020. From that time, NSW Health has provided extensive direction and support for a statewide public health response. The arrival of the Delta variant of the SARS-CoV-2 in NSW in May 2021 presented unique challenges to health and aged care facilities due to high morbidity and mortality of this variant. Like many health services globally, NSW Health was challenged by the scale, volume and speed of the spread of the Delta variant.

Prior to June 2021 there were relatively low COVID-19 case numbers in NSW due to strict border controls and measures such as social distancing, mask mandates and lockdowns. The Delta variant outbreak was declared on 16 June with <u>case numbers</u> rapidly escalating. Daily cases peaked at 1,351 on 15 September, 2021, and hospital activity six days later on 21 September with 1,268 patients in hospital, 242 patients in intensive care and 118 patients requiring ventilation. Case numbers gradually reduced before the arrival of the Omicron variant, which was first reported in NSW on 28 November, 2021.

Due to rapidly increasing case numbers a 'lockdown' in the Sydney metropolitan area commenced at the end of June 2021 and continued for 16 weeks. At the same time, the risk level was escalated to Red Risk Level¹ with restriction to visitors in NSW Health facilities and Residential Aged Care Facilities (RACF).

Significant attention was given to the prevention of transmission within the hospital system which included the provision of statewide Infection Prevention and Control (IP&C) guidance. Projected ambulance, Emergency Department activity, bed capacity, and Intensive Care utilisation indicated that additional initiatives were needed to manage demand. It was anticipated that if COVID-19-

¹ High risk of COVID-19 transmission

related incidents increased in line with predicted COVID-19 case numbers, conducting reviews in line with the processes mandated by NSW Health Incident Management Policy (<u>PD2020_047</u>) would be difficult for healthcare service organisations to sustain.

Evolution of COVID-19 Serious Incident Reviews

The CEC is the lead agency for patient safety and quality for NSW Health and worked with stakeholders from the NSW Ministry of Health (MOH), Agency for Clinical Innovation (ACI), and Local Health Districts (LHDs) / Specialty Health Networks (SHNs) to support health services throughout the pandemic. Specific <u>COVID-19 incident management</u> advice for Directors of Clinical Governance was developed in September 2021 to assist with the management of high numbers of COVID-19 incidents. Resources were shared on the CEC website and enabled a streamlined and consistent approach for LHDs/SHNs/health services to investigate COVID-19 related cluster outbreaks (clinical and corporate incidents) and patient deaths, and to respond to affected patients and families.

The CEC released the COVID-19 Incident Management Framework, which aimed to assist stretched health care resources in incident investigations.

Types of COVID-19 Serious Adverse Event Reviews

Serious incidents are notified and escalated within the Health Service and to the MOH via a Reportable Incident Brief (RIB) as per NSW Health Incident Management Policy (<u>PD2020_047</u>). In response to COVID-19, the following methodologies were approved:

Reviewing individual cases of COVID-19 patient death

Individual cases of COVID-19 patient deaths were required to have a SAER using a rapid root cause analysis (RCA) methodology, using a newly developed "SAER Individual COVID-19 incidents resulting in patient death" template.

Reviewing a COVID-19 patient cluster/outbreak in a healthcare setting

Clusters or outbreaks of COVID-19 were to be reviewed via a rapid RCA, using a newly developed "Cluster/outbreak review report" template and the report submitted to the MOH within 45 days of the cluster/outbreak being identified/notified.

Patient cases were reviewed via a rapid RCA for each patient death in the cluster/outbreak using the new "SAER Individual COVID-19 incidents resulting in patient death" template. SAER reports are submitted to the MOH within 60 days.

SAER reviews consider contributing system factors, risk factors, patient factors, and human factors.

Differences between the Preliminary Risk Assessment (PRA) and SAER processes

There were a number of differences between the usual PRA and SAER processes, and the revised COVID-19 processes, including:

- A delegate can convene a PRA team and/or a SAER team on behalf of the Chief Executive
- An expert panel for COVID-19 may be chosen for the PRA and/ or SAER members
- Standing appointments for PRA or SAER can name more positions than required. A record must be kept of actual team members
- Interviews are undertaken as deemed relevant

• The SAER report for individual COVID-19 cases is a combined findings and recommendations template.

COVID-19 Serious Incident Review Process

The CEC established an additional SIR Sub-Committee for COVID-19 specific incidents to focus on timely review of COVID-19 related incidents and to enable timely feedback to the healthcare system. The COVID-19 SIR Sub-Committee reports to the CRAG and is afforded statutory privilege under section 23 of the *Health Administration Act 1982*. In line with the CRAG Terms of Reference, documents created by and for the Sub-Committee are privileged and cannot be disclosed or released without the approval of CRAG.

The CEC's six SIR Sub-Committees of the CRAG (Figure 1) review all clinical SAER reports for the purpose of classification, theming and analysis to identify system wide learning and risks.



Figure 1: Serious Incident Review Sub-Committees of the CRAG

The COVID-19 SIR Sub-Committee (the Committee) was first convened on 10 November, 2021 with members from a broad range of clinical and corporate areas. The Committee included expert clinical representation from LHDs, SHNs, and NSW Health and Pillar organisations.

The Committee reviewed and analysed clinical and corporate incidents related to COVID-19. The purpose of the COVID-19 SIR Sub-Committee was to:

- Review and classify COVID-19 SAERs regarding reportable patient deaths received by the NSW MOH to identify clinical risk trends or issues with statewide implications.
- Review and classify other COVID-19 related SIRs as determined by the Co-Chairs.
- Review and classify COVID-19 cluster/outbreak reviews (corporate incidents) received by the NSW MOH to identify risk trends or issues that have statewide implications.
- Convey to CRAG identified system issues with recommendations for appropriate action.
- Undertake more detailed analyses of incidents or themes where it is considered issues may have broader relevance or statewide impact.
- Confirm any potential <u>Australian Sentinel Events</u> and notify the relevant LHD.
- Promote shared learning of findings across the health system as approved by CRAG.
- Periodically review and maintain the relevance of classification taxonomy.

COVID-19 SAER reports that contain elements that required the specialised review of the Clinical Management, Mental Health and Alcohol and Other Drugs, Maternal and Perinatal, Children and Young People, or the Prevention and Response to Violence Abuse and Neglect SAER Sub-Committees were referred for notation or review by that Sub-Committee. Conversely, SAER reports tabled at other SIR Sub-Committees that involved COVID-19 were also referred to the COVID-19 SIR Sub-Committee for notation and review.

Methods

Data collection

COVID-19-related incidents were investigated by LHDs/SHNs using the COVID-19-specific SAER templates developed by the CEC. The SAER reports were allocated to one of the Sub-Committee members by the secretariat prior to the meeting for initial review, then presented and discussed by the Sub-Committee. The COVID-19 SIR Sub-Committee meeting minutes provided a 'transcript' of discussions. This text was analysed as part of the development of this report.

Analysis methods

Two CEC analysts independently reviewed the transcripts. An analyst with experience in patient safety initially screened the data to identify phrases and sentences of interest as emerging themes and sub themes. A Patient Safety Analyst with qualitative research experience conducted a second process of data analysis. The transcripts were rescreened to check for any missed data and confirm the content-related themes. The analysts then met to discuss and clarify the themes and sub-themes. The data was returned to the Sub-Committee members for (member) checking² and finalisation.

Findings

Descriptive data

Clinical SAER Characteristics

Twenty seven (27) COVID-19 specific clinical SAER reports were received (ten in July, nine in August and four in September) and tabled at the three COVID-19 SIRs Sub-Committee meetings. The tapering in volume likely represents the statewide response in implementing containment strategies combined with declining case numbers. Clinical SAERs were received from five LHDs with 25 from metropolitan areas and two from rural services. The majority incidents occurred inhospital settings with three in community and one in virtual care.

Specific Service

The categories of clinical units reported are represented in Figure 2 and include Aged Care (n=9, 33%), general wards (n=6, 22%), rehabilitation, Medical Assessment Unit (MAU), Emergency Department Short Stay Unit (EDSSU), COVID-19 ward, Oncology and Neurology (n=1 each, 4% each)

² Member checking is a qualitative technique used to establish the tenet of credibility in trustworthiness. It is defined as sharing either a brief summary of the findings or sharing the whole findings with the research participants.



Figure 2: Volume of SAERs reviewed by specific service

The most prevalent risk factor identified through the analysis was physical co-morbidities, which was identified in 10 of the 27 SAERs (37%). Four identified Acute Coronary Syndrome as a risk factor. A wide range of risk factors was identified across the remaining SAERs, including mental health, abdominal pain, delayed response, altered call criteria, aspiration, compromised airway, anticoagulation use, close contact care and poor patient flow. There was greater homogeneity in patient factors with a high frequency of physical (n=12) and mental health (n=2) co-morbidities. In six of the SAERs, patients were from a culturally and linguistically diverse background.

There were 12 SAERs in which human factors were an element, including cognitive based errors (n=5), loss of situation awareness (n=3), skill-based error (n=2) and carer support/network (n=1).

Demographics

Patient demographics for the 27 clinical SAERs ranged from 27 to 96 years old. As expected, patients were older, with a median age of 80 and an average age of 74. Male:female ratio was 3:2. The age and gender split appears consistent with the COVID-19 admitted population during this period. The distribution of ages for clinical incidents is detailed in Figure 3 below.



Figure 3: Aged distribution of COVID-19 SAERs reviewed

Risk Factors

Patient risk factors were available for 22 SAERs and included close contact status (n=19), advanced age (n=2) and significant co-morbidities (n=1).

There was a range of presenting symptoms reported for 24 cases with a high proportion of respiratory symptoms (shortness of breath 21% (n=5), cough 21% (n=5), and tachypnoea 4% (n=1), cognitive impairment (n=5), febrile (n=3), gastrointestinal symptoms (n=1), hypothermia (n=1), sore throat (n=1), fatigue (n=1) and tachycardia (n=1).

Vaccination status was reported for all SAERs, with 11% (n=3) vaccinated, 30% (n=8) partially vaccinated, 15% (n=4) of unknown vaccination status, and 44% (n=12) unvaccinated.

COVID-19 tests were confirmed in 23 cases with positive results reported in 22 and unknown COVID-19 status in the remaining four cases.

The number of days to diagnosis post admission ranged from 4 to 170 days with a median of 14 days and an average of 19 days. Death was the outcome in 88 percent (n=24) of cases.

Corporate SAERs Characteristics

Four COVID-19 specific corporate review reports relating to clusters/outbreaks were received (two in July, one in September and one in October) and reviewed at the COVID-19 SIR Sub-Committee meetings. Corporate reviews were received from four LHDs with three clusters in metropolitan regions and one in a rural region. Units included mental health, aged care, surgical and an Emergency Department. The clusters involved a total of 67 patients (with cluster size ranging between one and 40 cases). Corporate review characteristics can be summarised as outcomes for services with the temporary closure of three wards. Of the four Corporate Reviews, two identified patient factors (mental health and treatment adherence), two identified human factors (cognitive based error and violation), and two identified system issues (testing).

Themes

The COVID-19 SIR Sub-Committee explored the 31 reports via case presentation and discussion. Qualitative data analysis identified eight themes with associated sub themes summarised in Table 2.

Number	Theme	Sub theme(s)
1.	Rapidly changing COVID-19	Dissemination of information from multiple sources
	information	Level of authorisation (national versus state)
2.	Limited interoperability of electronic record management systems	Access to patient information between services
3.	Delayed COVID-19 test results	
4.	Patient care issues	Inconsistent risk assessment
		Inconsistent risk management
		Inconsistent care planning
		Barriers to care
		Focus on COVID-19 management and lack of comprehensive care
5.	Facility design not meeting	Inadequate environmental ventilation systems
	requirements for a pandemic	Shared patient space
		Shared clinician space
6.	Shared medical equipment	Storage of shared medical equipment
		Cleaning of shared medical equipment
7.	Personal protective equipment (PPE) issues	Unavailability of PPE
		Inconsistent use of PPE
		Breaches in PPE
8.	Impact on health workers	High workload
		Physical, mental and emotional demands
		Lack of protected breaks

Table 1: COVID 19 SIR Themes and Sub-themes

Identified themes were explored to better understand the complexity of COVID-19 related incidents across the system, with the aim to develop data-driven recommendations for systems improvement.

1. Rapidly changing COVID-19 information

Issues relating to the provision of consistent and up-to-date COVID-19 information to the system were identified. This included national and state communications, which contributed to several sub themes implicating a delay in the translation of the rapidly changing information:

Table 2: Subthemes related to rapidly changing COVID-19 Information

Subtheme	Description
Dissemination of information from multiple sources	 Difficulty in maintaining guidance documents due to inconsistent dissemination and access to updated Series of National Guidelines (SoNG) for the Coronavirus (COVID-19) pandemic from the Australian Government Department of Health. Delayed communication to health workers of updated evidence-based practice, resulting in confusion about information and practice implementation.
Level of authorisation	 Facilities had difficulty making decisions about de-isolating patients due to rapidly changing national and state advice, and inconsistency in applying advice at a local level

2. Limited interoperability of electronic record management systems

A consistent theme across incidents was capturing and sharing patients' electronic medical records. There are long-standing issues regarding the NSW electronic medical record (eMR) system as it currently does not communicate between LHDs/SHNs/Health services or primary care settings. The system currently cannot access complete patient records although this will eventually be addressed through the implementation of a Single Digital Patient Record (SDPR).

3. Delay in COVID-19 test results

The lack of patient medical records integration likely also contributed to a delay in COVID-19 test results. This was in addition to other factors identified in the SAERs, including:

- Delays in COVID-19 test swab processing and communicating results meant patients were kept in <u>Amber (medium) risk</u> areas until their results were available
- Availability of point-of-care testing (e.g., polymerase chain reaction (PCR) PoC testing, Rapid Antigen Testing) during the reporting period led to delays in identifying positive COVID-19 patients and increased transmission risk.

4. Patient care issues

Patient care was a significant theme with five sub themes including inconsistent risk assessment, inconsistent risk management, inconsistent care planning, a focus on COVID-19 management, and barriers to care, all of which challenged comprehensive patient care.

Subtheme	Description
Inconsistent risk assessment	 No reliable structured process for risk assessment, leading to clinician dependant risk assignment and decision-making, particularly regarding bed management Use of non-validated risk stratification tools resulting in high-risk patients not identified and managed in accordance with their level of risk

Table 3: Subthemes related to patient care issues

Subtheme	Description
	 Lack of documentation when a patient's level of risk changed Lack of consistent and coordinated screening processes in some facilities which resulted in delays in identifying and isolating patients who were COVID-19 positive.
Inconsistent risk management	 Introduction of ad hoc processes to segregate patients according to perceived level of risk increased the risk of transmission for patients in the <u>Amber (medium) risk</u> category Cohorting of patients who had been risk assessed as "close contacts" Moving patients out of single rooms into non-cohort matched shared rooms resulting in COVID-19 transmission Reactive bed management resulting in patients having multiple bed moves within and between wards increasing the risk of exposure and transmission (and geriatric syndromes for the older person e.g., falls, pressure injuries, delirium and incontinence) Barriers to provision of an inpatient vaccination program
Inconsistent care planning	 "Outside the room" assessment where some patients did not undergo physical examination and observations were not performed. This led to both misdiagnosis and failure to recognise clinical deterioration. Facilities established ad hoc/individual COVID-19 care pathways. Lack of uniform escalation processes when services were unable to make contact with patients who were confirmed as having COVID-19 Lack of, or rapid development of protocols not considering the frequency of calls and welfare checks for community-based patients with confirmed COVID-19, including considering the severity of underlying chronic diseases and other risk factors to increase the frequency of contact Lack of collaboration in care planning for patients with Alcohol and Other Drug (AOD) co-morbidities while isolating in the community for COVID-19.
Focus on COVID-19 management with challenges to comprehensive care	 Service management focused on "COVID" versus "Non-COVID" patient groups that meant complex patient needs were not recognised. Patients with mental health issues who had high-risk behaviours in the community prior to admission were not managed in line with usual practice, increasing the risk of inpatient COVID-19 transmission. Difficulty managing patients who had delirium/cognitive impairment leading to increased risk to both patients and health worker safety and increased risk of virus transmission Increased use of anti-psychotic medications Difficulty containing patients who were wandering, noting the complex balance between patient autonomy versus the right to restrict movement to protect other patients and the workforce. This led to patient and family distress and ethical challenges to clinicians. Sub-optimal management and support for patients with AOD issues during withdrawal while in isolation in the community for COVID-19.
Barriers to care	 Patients could not transfer to tertiary centres for emergency specialist surgery.

5. Facility design not meeting specifications for a pandemic

Facility design featured as an important contributing factor to incidents. The sub themes that emerged in the analysis included environmental design and shared spaces for patients and health workers.

Subtheme	Description
Environmental ventilation systems	Many facilities are older, with some identified in the investigations as not fit for COVID-19 purposes. A fundamental design requirement now recognised in respiratory and infectious diseases pandemics relates to adequate ventilation systems. Buildings for health service delivery should be purpose-built as modifications may have difficulty complying with the multiple specifications required. Specific to the COVID-19 incidents analysed, inadequacies were:
	 Environmental ventilation systems were compliant with industry standards but inadequate for preventing transmission of COVID-19 in facilities Insufficient number of negative pressure rooms and isolation capacity
Shared patient spaces	Emergency Departments had insufficient space for screening patients, with most screening stations situated inside departments resulting in unconfirmed positive cases entering the department before additional interventions or optimal patient placement could be implemented.
	 Wards had a number of design concerns, including: Insufficient purpose-built clinical areas to care for patients with confirmed or suspected COVID-19, which meant infection prevention and control precautions could not be maintained Narrow corridors did not allow for adequate distancing between patients and health workers Shared bathrooms resulted in confirmed, suspected and negative patient cohorts mixing Lack of availability of single rooms to meet high demand and
	disease burden.
Shared health worker spaces	 Check in/out procedure to shared spaces was lacking, which made contact tracing difficult Lack of suitable outside areas for breaks Tea rooms accessed by multiple health workers Health workers not physically distancing in the shared spaces and not replacing face masks immediately after eating and drinking.

Table 4: Subthemes relating to facility design not meeting specification for a pandemic

6. Shared medical equipment

The storage and cleaning of medical equipment was a strong theme. When equipment was shared it required identification and attention to both storage and cleaning.

Table 5: Subthemes relating to shared medical equipment

Subtheme	Description
Storage of shared medical equipment	 Medical equipment was shared between clinical areas/rooms, which increased the chance of transmission.
Cleaning of shared medical equipment	 Increased requirements for vigilance and cleaning of any shared equipment which was usually performed by clinicians and resulted in greater workloads

7. Personal Protective Equipment

Personal Protective Equipment (PPE) sub themes included unavailability of PPE, inconsistency of PPE use, and breaches in the donning and doffing of PPE.

Table 6: Subthemes relating to personal protective equipment

Subtheme	Description
Availability of PPE	 Noting that these incidents occurred over a year into the pandemic and measures had been applied at the state level to ensure the adequate supply of suitable PPE, it is surmised that the supply issue identified at facility or ward level and/or surges in clinical activity may have accounted for: Insufficient availability of PPE at PoC
	 Difficulties in the procurement of required range and volume of PPE Lack of access to fit testing of respirators for clinicians
Inconsistent use of PPE	 Inconsistency in the type of PPE and the donning/doffing of PPE
Breaches in PPE	Despite extensive workforce initiatives to ensure health workers were familiar with PPE requirements as central to infection prevention and control, a number of investigations highlighted breaches in the correct use of PPE. In particular:
	 Health workers not wearing masks or respirators and eye protection in accordance with PPE guidelines.

8. Impact on health workers

The final theme identified was the contribution of the impacts of the incidents on health workers. There were three sub themes: high workload, physical, mental and emotional impact, and the lack of protected breaks for health workers.

Table	7:	Subthemes	relating	to	impact	on	health	workers
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Subtheme	Description
High workload	 Health workers overwhelmed by unprecedented demand for health services
Physical, mental and	Related to the high workload was the impact that this had on staff in terms of physical, mental and emotional:

Subtheme	Description
emotional impact	 Health workers' uncertainty and fear of exposure to the virus led to a focus on pandemic requirements, not patient-centred or self-care
Lack of designated uninterrupted breaks	 Multiple incidents highlighted the risks associated with breaks for the health workers. Several issues were identified including: The perceived quality of breaks diminished with increased risk of virus transmission Health workers needing to be hyper-vigilant when on break, contributing to reduced quality of breaks Interrupted breaks with donning and doffing masks multiple times to avoid health workers taking masks off at the same time to eat and drink Lack of time or suitable outside area to access for a safer break

Lessons and safety recommendations

Lessons

The COVID-19 SIR Sub-Committee was able to identify lessons, strategies and actions that can mitigate risks associated with the nosocomial spread of COVID-19 within NSW Health facilities. These include improvements related to timely collection and reporting of COVID-19 testing, a mandate for mask wearing, introduction of the Respiratory Protection Program (RPP), a mandate for healthcare staff vaccination, and changes in Emergency Department operations.

It is noted that the themes described above and the resulting lessons are valuable in considering the planning or responding to other Acute Respiratory Infections such as influenza or respiratory syncytial virus.

Lesson one: improved collection and reporting of COVID-19 tests

The introduction of Rapid COVID-19 and PoC testing allowed for more timely identification of COVID-19 positive cases and earlier and appropriate isolation and bed management to reduce transmission. Subsequent protocols for testing and repeat testing for the duration of the patient journey has increased the reliability of bed management decisions and reduced the risk of patient, visitor and health worker exposure to COVID-19.

Lesson two: mandated mask wearing

The introduction of mandatory face masks, respirators and eye protection in clinical areas has reduced the risk of transmission for both patients and health workers and minimised the need for staff furloughing. This has been further enhanced by initiatives such as the Respiratory Protection Program (RPP)

Lesson three: Respiratory Protection Program (RPP)

The rapid establishment of a RPP in NSW sought to ensure that frontline health workers were fit checking every time a respirator was donned. Staff were fit-tested to ensure the most appropriate style of respirator was donned to reduce the risk of in-hospital transmission and health worker infection. It may have also played a role in reducing the incidence and severity of mask-related pressure injuries where poorly fitting masks contributed to skin injury.

Lesson four: mandated health worker vaccination

The introduction of mandatory health worker vaccination reduced the likelihood of severe illness that required hospitalisation.

Lesson five: emergency setting changes

The implementation of screening stations, which were manned by experienced Emergency Department triage nurses supported staff to rapidly identify patients requiring urgent care or transfer to the COVID-19 <u>Red (high) risk zone</u>. In addition, there were initiatives for the prompt transfer of "Red" paediatric patients, to minimise patients in the ED waiting room, and introduction of Rapid Antigen Testing prior to hospital admission.

Safety recommendations

This report details important findings from clinical and corporate serious incident reviews identified by the COVID-19 SIR Sub-Committee. Qualitative analysis has supported the need for evidencebased recommendations to continue in order to review models of care related to COVID-19. This information should be shared with expert clinical groups and partner agencies, such as the Agency for Clinical Innovation.

The COVID-19 SIR Sub-Committee also identified that enhanced communication processes are required when aligning changes in national guidelines with the multiple NSW COVID-19 guidelines, to ensure accessible, clear and timely dissemination of new evidence across the NSW Health system.

Ongoing efforts to strengthen the eMR and pathology systems to allow integration with all clinical services to use and access patient information within the same system have been highlighted as a priority through COVID-19 SIR feedback to eHealth NSW.

Conclusion

This report provides a snapshot of the initial series of serious incident reviews by the newly convened COVID-19 SIR Sub-Committee of the CRAG. It summarises 31 COVID-19 clinical and 4 corporate incidents reviewed by the Sub-Committee and provides some early learnings.

Further analysis of the findings from the COVID-19 SIR Sub-Committee will be undertaken to identify and share any future learnings.